Save America's Rural Hospitals Act Section-By-Section

Section 1. Short Title; Table of Contents

(a) Short Title.
(b) Findings.

Title I – Rural Provider Stabilization

Subtitle A – Rural Hospitals

Sec. 101 – Eliminating Medicare Sequestration for Rural Hospitals.

60 days after the enactment of this Act, sequestration is permanently suspended for: critical access hospitals, sole-community hospitals, Medicare-dependent hospitals, small rural hospitals, or a hospital located in a rural area.

Sec. 102 – Reversing Cuts to Reimbursement of Bad Debt for Critical Access Hospitals and Rural Hospitals.

Changes the bad debt a rural hospital is liable for from 30 percent to 15 percent for cost reporting periods beginning more than 60 days following enactment.

Sec. 103 – Extending Payment Levels for Low-Volume Hospitals and Medicare-Dependent Hospitals.

Extends permanently, beyond fiscal year (FY) 2022, increased payments for Medicare-Dependent Hospitals and Low-Volume Hospitals.

Sec. 104 – Reinstating Revised Diagnosis-Related Group Payments for Medicare-Dependent Hospitals and Sole-Community Hospitals.

Reinstates, for FY 2022 and beyond, for Medicare-Dependent Hospitals and Sole-Community Hospitals, payments for the value-based incentive programs and payments under the hospital readmissions reduction program.

Sec. 105 – Reinstating Hold Harmless Treatment for Hospital Outpatient Services for Sole-Community Hospitals.

Reinstates hold harmless provisions for sole-community hospitals for FY 2022 and beyond.

Subtitle B – Other Rural Providers

Sec. 111 – Making Permanent Increased Medicare Payments for Ground Ambulance Services in Rural America.

Makes permanent the two percent urban, three percent rural, and 22.6 percent super rural ground ambulance payments. These are currently set to expire December 31, 2022.

Sec. 112 – Extending Medicaid Primary Care Payments.

Extends Medicaid primary care payments for rural providers permanently. These increased Medicaid payments were included in the Affordable Care Act (ACA) and allows higher payment to apply to primary care services. This provision will only extend these payments for rural providers.

Sec. 113 – Making Permanent Medicare Telehealth Service Enhancements for Federally Qualified Health Centers and Rural Health Clinics.

This section continues Section 3604 from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to serve as distant site providers. This section also updates and improves payments for services provided by FQHCs and RHCs to be equal to in-person services provided.

Sec. 114 – Creation of Reporting Requirements for Provider-Based Rural Health Clinics.

In December 2020, with passage of the Consolidated Appropriations Act (CAA), 2021, provider-based (PB) RHCs created after December 31, 2019, became subject to 'capped rates' also updated in the CAA, 2021. In April 2021, with passage of a Medicare sequestration relief extension, Congress moved the date PB RHCs were subject to the 'capped rate' from December 31, 2019, to December 31, 2020. However, moving forward, PB RHCs are unable to be reimbursed at their 'uncapped rates.'

This provision requires the Secretary of the Department of Health and Human Services (HHS) to consult with stakeholders to create a PB RHC quality reporting program for PB RHCs to voluntarily take part in. In exchange for participation in the PB RHC quality reporting program, PB RHCs created on or after January 1, 2021, will be eligible for the historic 'uncapped rate.'

Title II – Rural Medicare Beneficiary Equity

Sec. 201 – Equalizing Beneficiary Copayments for Services Furnished by CAHs.

Effective the calendar year (CY) following the enactment of this legislation, this provision equalizes beneficiary copayments for services furnished by critical access hospitals (CAH) to 20 percent of the lesser of the actual charge or payment.

Title III – Regulatory Relief

Sec. 301 – Eliminating 96-hour Physician Certification Requirement with Respect to Inpatient CAH Services.

Effective the CY following enactment of this legislation, the 96-hour Physician Certification Requirement will be permanently repealed. This requirement was temporarily removed via the 1135 Waiver Authority granted to the Centers for Medicare and Medicaid Services (CMS) during the COVID-19 public health emergency (PHE).

Sec. 302 – Rebasing Supervision Requirements.

This section revises supervision requirements for rural providers, removing barriers to care. The section creates an exceptions process for high-risk or complex medical services. This provision would also apply to outpatient Critical Access Hospital services.

Sec. 303 – Reforming Practices of Recovery Audit Contractors Under Medicare

Simplifies claim practices and recovery audit contractor practices under Medicare for rural providers, removing barriers to care.

Title IV – Future of Rural Health Care

Sec. 401 – Medicare Rural Hospital Flexibility Program Grants

Reauthorizes the Medicare Rural Hospital Flexibility Program. This section provides technical assistance support for CAHs and rural PPS hospitals hoping to transition to the newly created (within the CAA, 2021) rural emergency hospital (REH) designation. Additionally, this section provides a new item for rural health transformation grants to help eligible rural health providers transition to new models and evolve to meet community needs and their changing health care environment.